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Form for the new Tall Ones

Date:

Before you begin, we would like to know to whom we owe an immense THANK YOU! for having referred you to us: _____

Please fill out all questions to the best of your knowledge. Thank you.

Personal information

(Please fill out with a pen)

First name:_____ Last name:_____

Gender: ☐ F ☐ M ☐ Other

Date of birth: _____

Address: _____

Town/municipality/village: _____

Code postal: _____

Phone Home: _____ Work: _____

Cellular: _____

Email: _____

Can we send emails to this address including a monthly private newsletter? □ Yes □ No

How would you like us to confirm your appointment?

☐ Phone ☐ Email

Contact in case of emergency: Name_____ Phone # _____

Quebec health insurance number: _____ Exp _____

What is your occupation? _____

Where do you work? _____

Are you: ☐ single ☐ married ☐ with a partner ☐ divorced ☐ widowed

What is the name of your life partner? _____

What are the names of your children and their ages? _____

Present history

Please tell us your story in your own words. If you are consulting us for wellness, tell us what else you are doing to improve this state. If you are consulting for a particular issue, tell us how you think this started, what has happened to you and what you have done since. You can add other sheets if necessary.

Have you consulted another specialist for the same reason that brings you here?

☐ No
☐ Yes If yes, who?_____ When?_____
And what was the result?_____

Have you ever received chiropractic care before?

☐ No
☐ Yes If yes, who was your chiropractor? _____

Date of last adjustment: _____

What did you like best about the care? _____

What did you like least about the care? _____

Secondary objectives

Are there any other reasons for seeking care that you would like to have addressed eventually?

Life history

As best as you know, how did your pregnancy go (when your mother was pregnant with you) and your birth?

Have you been a victim of birth trauma like

☐ Induction (provoked labour) ☐ C-section ☐ Other
☐ Peridural/epidural/anesthesia ☐ Forceps or vacuum

Have you received routine vaccinations? Yes/No Date of most recent vaccines: _____

Have you suffered from adverse reactions following vaccination? Yes No

How was your health in general when you were…

- A child?_____
- A teenager?_____
    - Were you very involved in sports?_____
        - Which sports in particular?_____
    - If you are a woman, how was the beginning of your periods?_____
- An adult?_____

Date of the last bloodwork: _____

Do you suffer from imbalances like:

☐ Elevated cholesterol ☐ Diabetes ☐ Other chronic problem, specify:
☐ Hypertension ☐ Anemia

Have you ever…

Had surgery? ☐ No
☐ Yes If yes, when and why?_____

Been a victim of falls, car collisions or other trauma? ☐ No
☐ Yes If yes, when and briefly describe:

_____

Broken any bones or lost consciousness? ☐ No
☐ Yes If yes, when and briefly describe:

_____

Been hospitalized? ☐ No
☐ Yes If yes, when and why? _____

Family history

Are your mother and/or father in good health? Yes No

- If No, briefly specify:
- Is there a history in the family of heart problems
- Is there a history of heart or thyroid conditions or particular cancers in the family?

If you have brothers, sisters and/or children, are they healthy? Yes No

- If No, briefly specify:

Lifestyle

Do you take any medications (drugs), including the birth-control "pill"? ☐ No

☐ Yes If Yes, which ones?_____

Since when and at what dosage?_____

Do you take any supplements, including vitamins? ☐ No

☐ Yes If Yes, which ones?_____

Since when and at what dosage?_____

Do you take any coffee, tea and/or soft drinks? ☐ No

☐ Yes If Yes, how many?_____

Do you smoke cigarettes, marijuana and/or hashish? ☐ No

☐ Yes If Yes, how many? _____

Do you drink alcohol? ☐No

☐ Yes If Yes, how much? _____

According to you, do you drink enough water? ☐Yes ☐No ☐I do not know

How many glasses of water do you drink every day?_____

Do you exercise regularly? ☐No

☐Yes, If Yes, what do you do? _____

At what intensity? ☐Low ☐Moderate ☐Intense

How many times per day or per week?_____

How many hours do you sleep at night? _____

Your sleep is good? ☐Yes ☐ No

What position do you sleep in? _____

How old is your mattress? _____

How old is your pillow? _____

Do you consider your diet to be healthy? ☐Yes ☐No

Are you vegetarian?_____

Do you eat fish and if so, how often? _____

How many portions of cow's milk do you drink every day?_____

Do you often eat…

☐Meals prepared and cooked at home ☐ Meals at a restaurant

☐Meals that are prepared in advance by a store or a company?

What are your hobbies and/or your passions?_____

_____

Systems Review

Do you suffer from difficulties with…

- ☐ Your eyes – recurrent infections, cross-eyed, near-sightedness, far-sightedness…
- ☐ Your ears – ear infections, hearing difficulty, constantly hearing sounds…
- ☐ Your nose or your sinuses – congestion, frequent colds, sinusitis, allergies…
- ☐ Your mouth or your throat – abcesses, frequent sore throats…
- ☐ Your digestion – acid reflux, difficulty digesting certain foods, allergies…
- ☐ Your elimination – frequent diarrhea or constipation, difficulty/pain on urination…
- ☐ Your lungs and respiration – difficulty breathing, chronic bronchitis, COPD, asthma…
- ☐ Your heart – heart problems, feeling of palpitations, high or low blood pressure…
- ☐ Your nervous or vascular system – headaches, migraines, light-headedness, vertigo, loss of consciousness, trembling/shaking, numbness, memory loss…
- ☐ Your skin – frequent irritations, unusual pimple or plaques, rash, eczema, psoriasis…
- ☐ Your osseous and articular systems – articular pains…
- ☐ Your emotional health – towards work, home, school, finances, pregnancy, your role as a natural caregiver, loss of a loved one…
- ☐ Your psychological health – Depression, irritability, fatigue, nervousness…
  - Not too stressed?
- ☐ Your fertility – difficulties to conceive, miscarriages…
- ☐ Your genital system –
  - For women: menstrual pain, symptoms of menopause…
  - For men: erectile difficulties, lowering of libido…

Expectations

What are your expectations by coming here?

Do you wish to receive care to…

- Reduce symptoms to diminish pain
- To restore your health
- To maintain your health
- To increase your level of well-being (better-being)

Health and Quality of life are among the most precious things in this world – YOUR HEALTH AND YOUR FAMILY'S HEALTH. Chiropractic is there for You. The adjustments will help you to express your full potential of life. When you receive a chiropractic adjustment, the work has just begun. During the hours and days that follow your adjustment, your Innate Intelligence will continue to work by using the information received during the adjustment in order to make you better and help you. At the Maison Chiropratique Petits et Grands, we adjust people and the body decides, with its Innate Intelligence, what needs to be done, and what can still be done. Hence, we work in harmony with your inner wisdom. However, this process implies that you take back control of life and of your health, and that you accept to invest yourself in assisting "Dr You".

I recognize that the given information is exact to the best of my knowledge and I consent to receive any necessary examinations.

_____ _____

Signature **Date**